U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 25Oct2001

Case No: 1999-BLA-1299

In the Matter of

ISABELL TAYLOR, Widow of
JOHN LLOYD TAYLOR, Deceased
Claimant

v.

RAG AMERICAN COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:

Thomas E. Johnson, Esq.
JOHNSON, JONES, SNELLING, GILBERT & DAVIS
Chicago, Illinois
For Claimant

Scott White, Esq.
WHITE & RISSE
St. Louis, Missouri
For the Employer

BEFORE: RUDOLF L. JANSEN
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended. 30 U.S.C. § 901 *et seq.* Under the Act, benefits are awarded to coal miners who are totally disabled due to

pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis, commonly known as black lung, is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. § 902(b).

On August 30, 1999, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held in Evansville, Indiana on November 29, 2000. The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. They also are based upon my observation of the appearance and demeanor of the witnesses who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit received into evidence has been reviewed carefully, particularly those related to the miner's medical condition. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to "DX", "EX", and "CX" refer to the exhibits of the Director, Employer, and Claimant, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

1. Whether the miner had pneumoconiosis as defined by the Act and regulations;

2. Whether the miner's pneumoconiosis arose out of coal mine employment; and

3. Whether the miner's death was due to pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

John Lloyd Taylor, Claimant's husband and the miner upon whom this claim is based, was born on December 5, 1918 and died on June 14, 1997. Claimant and the miner were married on May 25, 1939, and they resided together until the miner's death. They had no children who were under eighteen or dependent upon them at the time this claim was filed. At the time of the

hearing, Claimant resided in Boonville, Indiana and had not remarried. (DX 01)

On his original claim for benefits, Mr. Taylor complained of shortness of breath and chest pains on exertion. Claimant affirmed these complaints on her claim. It was consistently reported that Mr. Taylor started smoking cigarettes in 1938. The rate at which he smoked cigarettes varies in its report from one-half package per day to one and one-half packages per day. (DX 24) It is reported with fair consistency that he stopped smoking in the mid-1970's. Syed Abrar Ali, M.D., examined Mr. Taylor on many occasions, and served as attending physician for his multiple hospitalizations for lifesaving treatments. Dr. Ali noted that Mr. Taylor quit smoking in 1977. (DX 24) Accordingly, I find that Mr. Taylor smoked cigarettes at a rate of one and one-half packages per day from 1938 to 1977.

Claimant, Isabell Taylor, timely filed her application for survivor's benefits under the Act on June 2, 1998. The Office of Worker's Compensation Programs awarded the claim on July 7, 1999. Pursuant to Employer's request for a formal hearing, the case was transferred to the Office of Administrative Law Judges on August 30, 1999. (DX 26)

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. At the hearing, the parties stipulated that Miner worked forty years in qualifying coal mine work. (Tr. 09) Based upon my review of the record, I accept the stipulation as accurate and credit Mr. Taylor with forty years of coal mine employment.

The Miner's last coal mine employment was as a shovel oiler. In this capacity, he was required to climb four to five flights of stairs, approximately 60 feet, to the gantry of the shovel. He cleaned and oiled the shovel from this position, with continuous exposure to rock, shale, and coal dust. (DX 24)

MEDICAL EVIDENCE

X-ray reports

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 09	06-10-97	06-10-97	Linge / Unknown	Left lobe infiltrate
DX 09	06-07-97	06-07-97	Linge / Unknown	Left lobe infiltrate
DX 09	06-04-97	06-04-97	Linge / Unknown	Left lobe infiltrate
DX 09	03-11-97	03-12-97	Linge / Unknown	Clear
DX 17	09-23-94	09-24-94	Linge / Unknown	No active chest disease
DX 24	03-25-94	02-13-95	Lee / BCR, B	1/1
DX 24	03-25-94	08-26-94	Aycoth / BCR, B	1/1
DX 17	03-25-94	03-25-94	Linge / Unknown	Infiltrates resolved
DX 17	03-14-94	03-14-94	Linge / Unknown	Increased right infiltrates
DX 17	03-10-94	03-10-94	Linge / Unknown	Pneumonia
DX 17	03-07-94	03-07-94	Linge / Unknown	Pneumonia
DX 17	01-12-94	01-12-94	Linge / Unknown	No significant chest abnormality
DX 24	11-19-86	01-15-87	Bridges / BCR, B	Completely negative
DX 24	11-19-86	01-07-87	McGraw / BCR, B	Negative
DX 24	11-19-86	11-19-86	Linge / Unknown	Negative
DX 24	06-19-84	06-24-85	Bridges / BCR, B	Negative
DX 24	06-19-84	06-12-85	McGraw / BCR, B	Negative
DX 24	06-19-84	08-10-84	Sargent / BCR, B	Negative
DX 24	06-19-84	06-19-84	Calhoun / Unknown	1/1
DX 24	04-27-82	05-28-85	Bridges / BCR, B	Negative
DX 24	04-27-82	05-17-85	McGraw / BCR, B	Negative
DX 24	04-27-82	04-27-82	Brown / Unknown	Negative

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 24	02-20-81	05-21-85	Bridges / BCR, B	Negative
DX 24	02-20-81	05-02-85	McGraw / BCR, B	Negative
DX 24	02-20-81	01-27-82	Smith / BCR, B	Completely negative
DX 24	02-20-81	02-22-81	Noveroske / BCR	Completely negative

"B" denotes a "B" reader and "BCR" denotes a board-certified radiologist. A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services (HHS). A board-certified radiologist is a physician who is certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* 20 C.F.R. § 718.202(a)(ii)(C). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

Narrative Medical Evidence

The record contains numerous hospital records and consultation records generated during multiple hospitalizations in the last years of Mr. Taylor's life. (DX 24) Syed Abar Ali, M.D., was the attending physician for Mr. Taylor during these final hospitalizations. Dr. Ali relied upon a coal mine history of forty-two years and a smoking history of one package of cigarettes per day for approximately twenty years, ending in 1977. He reviewed negative x-rays and pulmonary function studies showing a restrictive defect. Dr. Ali diagnosed pneumonia, chronic obstructive pulmonary disease, atherosclerotic heart disease, angina pectoris, and hypertension, and noted evidence of a previous myocardial infarction and a bilateral femoral popoliteal bypass graft.

Dr. Ali was deposed on January 19, 1987. (DX 24) He opined that there was insufficient evidence to diagnose chronic obstructive lung disease. Following Mr. Taylor's death, Dr. Ali attributed his demise to respiratory failure. (DX 09) Dr. Ali was Board Eligible in Internal Medicine in 1987, but his current credentials are not of record.

Mr. Taylor was examined by Daniel Combs, M.D., on October 18, 1994. (DX 24) Based upon a twenty-five year smoking history, a forty-eight year coal mining history, a positive x-ray, hypoxemia, and an obstructive respiratory defect, Dr. Combs diagnosed Mr. Taylor with coal workers' pneumoconiosis. Dr. Combs' credentials are not of record.

On November 19, 1986, Mr. Taylor was examined by David W. Howard, M.D. (DX 24) Dr. Howard noted a thirty-eight year coal mining history and one package per day smoking history of thirty-eight years. Based upon x-rays, pulmonary function and arterial blood gas studies, he opined that the miner suffered from a moderate obstruction due to his smoking history. He also opined that Mr. Taylor did not have cor pulmonale. Dr. Howard was deposed on January 23, 1987, expressing conclusions consistent with his medical report. (DX 24) Dr. Howard is Board Certified in Internal Medicine and Pulmonary Disease.

Mr. Taylor was examined by Neal Calhoun, M.D., on June 19, 1984. (DX 24) Dr. Calhoun noted a forty-two year coal mine history and a one and one-half package per day smoking history spanning twenty years, ending in 1970. Based upon a positive x-ray, pulmonary function studies showing moderate to severe "difficulty," and arterial blood gas studies showing "quite a deficit," he opined that the miner had coal workers' pneumoconiosis and arteriosclerotic heart disease. He also diagnosed cor pulmonale. Dr. Calhoun's credentials are not of record.

Upon Mr. Taylor's death, Miles J. Jones, M.D., performed an autopsy and indicated on the death certificate that Mr. Taylor died of respiratory failure, pulmonary edema, left lower lobe pulmonary infarction, and pulmonary embolis. (DX 07) In a separate, undated, pathology report, Dr. Jones reviewed x-rays, pulmonary function and arterial blood gas studies. He diagnosed Mr. Taylor with pulmonary edema, bronchopneumonia, centrilobular emphysema, pneumoconiosis, cardiomegaly, cor pulmonale, and bilateral pleural effusions. He opined that the existence of pneumoconiosis induced cor pulmonale hastened the miner's death. Dr. Jones is Board Certified in Pathology and Forensic Pathology.[1]

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[1] I take judicial notice of Dr. Miles Jones' credentials. *See generally Maddaleni v. The Pittsburg & Midway Coal Mining Co.,* 14 BLR 1-135 (1990).

P. Raphael Caffrey, M.D., provided a pathology report dated July 1, 1999. (DX 20) Dr. Caffrey reviewed eleven pathology slides, and noted a forty year coal mining history as well as Mr. Taylor's status as a former smoker. He diagnosed Mr. Taylor with chronic bronchitis, bronchopneumonia, pulmonary edema, simple pneumoconiosis, and centriacinar emphysema.

Dr. Caffrey offered a supplemental report dated December 6, 1999. (EX 05) He diagnosed Mr. Taylor with chronic obstructive pulmonary disease induced by smoking, vascular disease, hypertension, prostate cancer, cardiac failure, and pneumonia. Dr. Caffrey was deposed on January 19, 2001. (EX 16) He opined that Mr. Taylor's death was a result of cardiac failure with congestive heart failure, but that his emphysema and bronchitis did not contribute to his cardiac condition. Dr. Caffrey is Board Certified in Pathology.

Jerome Kleinerman, M.D., provided a pathology report dated June 13, 1999. (DX 19) Dr. Kleinerman reviewed x-rays, arterial blood gases and eleven pathology slides. He noted Mr. Taylor's status as a former smoker. He diagnosed the Miner with simple coal workers' pneumoconiosis, but opined that his death was a result of cardiac failure. Dr. Kleinerman is Board Certified in Pathology.

Richard L. Naeye, M.D., reviewed eleven pathology slides and submitted a pathology report dated May 19, 1999. (EX 18) Dr. Naeye diagnosed mild to moderate pneumoconiosis, but opined that Mr. Taylor's death was not caused by the pneumoconiosis. Dr. Naeye provided a supplemental report dated December 2, 1999. (EX 03) Upon reviewing x-rays, pulmonary function and arterial blood gas studies, as well as other medical reports, and noting a smoking history of one package of cigarettes per day for twenty-five years, he continued to opine to the presence of pneumoconiosis. Dr. Naeye is Board Certified in Pathology.

Grover M. Hutchins, M.D., provided a pathology report dated September 9, 1999. (EX 01) Dr. Hutchins reviewed medical records and examined eleven pathology slides. He opined that Mr. Taylor had mild simple silicosis and mild simple pneumoconiosis, but that these conditions were too mild to cause death. He provided a supplemental report dated February 12, 2000. (EX 07) In this report, he reviewed x-rays and pulmonary function studies, adding chronic obstructive pulmonary disease to his diagnoses of Mr. Taylor. He noted forty years of coal mining and a one and one-half package per day smoking history of

twenty years. He continued to opine that Mr. Taylor's death was not caused or hastened by coal dust exposure. Dr. Hutchins is Board Certified in Pathology.

Jerrold Abraham, M.D., provided a pathology report dated November 8, 2000. (CX 02) Dr. Abraham noted a forty-two year coal mining history. He diagnosed Mr. Taylor with coal workers' pneumoconiosis and emphysema. He opined that the presence of pneumoconiosis made it more likely for Mr. Taylor to develop respiratory and cardiac failure when he did. He also noted extensive fibrosis and changes consistent with cor pulmonale. Dr. Abraham provided a supplemental report concluding consistently with his original report. (CX 03) Dr. Abraham is Board Certified in Pathology.

Francis H. Y. Green, M.D., provided a pathology report dated November 9, 2000. (CX 04) Dr. Green noted a forty year coal mining history, a smoking history of thirty-four to fifty pack years. He reviewed x-rays, pulmonary function and arterial blood gas studies. Dr. Green diagnosed Mr. Taylor with moderate pneumoconiosis, severe chronic bronchitis, severe emphysema, focal alveolar edema, pulmonary vascular changes, cor pulmonale, and silicosis. He attributed the pneumoconiosis and most of the obstructive pulmonary defects to coal dust exposure. He opined that the Miner died a respiratory death caused by pneumoconiosis, pulmonary obstruction, and pneumonia. Dr. Green is Board Certified in Pathology.

Lawrence Repsher, M.D., submitted an independent medical review dated December 9, 1999. (EX 06) Dr. Repsher noted a forty-two year coal mining history and a one-half to a one and one-half package per day smoking history spanning thirty eight years. He diagnosed Mr. Taylor with simple coal workers' pneumoconiosis, coronary artery disease, hypertension, and diabetes. He opined that the pneumoconiosis was too mild to cause or hasten death, and that Mr. Taylor died from pulmonary emboli. Dr. Repsher is Board Certified in Internal Medicine and Pulmonary Disease.

Gregory J. Fino, M.D., performed an independent medical review on February 22, 2000. (EX 12) Dr. Fino noted forty-two years of coal mining and found every pulmonary function test after 1981 to be invalid. He diagnosed pathological pneumoconiosis but found no valid objective evidence of impairment from pneumoconiosis. He does opine that Mr. Taylor was totally disabled from other respiratory problems.

Dr. Fino was deposed on January 5, 2001. (EX 15) Upon reviewing x-rays, invalid pulmonary function studies and arterial blood gas studies performed during acute illness, he diagnosed Mr. Taylor with pneumoconiosis, chronic obstructive pulmonary disease, emphysema, and pulmonary emboli. He opined that the miner did not have cor pulmonale, and that pneumoconiosis was not a cause of death. Dr. Fino is Board Certified in Internal Medicine and Pulmonary Disease.

Peter G. Tuteur, M.D., provided an independent medical review dated December 6, 1999. (EX 04) Dr. Tuteur diagnosed mild simple coal workers' pneumoconiosis, and opined that Mr. Taylor died as the result of pulmonary emboli. Dr. Tuteur was deposed on November 27, 2000. (EX 14) He again diagnosed pneumoconiosis, emphysema, chronic bronchitis, pulmonary emboli, and cor pulmonale. He opined that Mr. Taylor's death was a respiratory death caused by chronic bronchitis, emphysema, and pulmonary emboli, but not pneumoconiosis. Dr. Tuteur is Board Certified in Internal Medicine and Pulmonary Disease.

Robert A. C. Cohen, M.D., submitted an independent medical review dated November 9, 2000. (CX 01) Dr. Cohen reviewed x-rays, pulmonary function and arterial blood gas studies, and the autopsy slides and report. He noted forty-two years of coal mining and a one to one and one-half package per day smoking history of thirty-three years. Dr. Cohen diagnosed pneumoconiosis and emphysema, and opined that Mr. Taylor was suffering from a severe obstructive defect. He further opined that Mr. Taylor's pneumoconiosis compromised his lung capacity, preventing him from withstanding the combined insults of pneumonia and emboli. Without the underlying pneumoconiosis, he opined that the miner would have lived longer. Dr. Cohen is Board Certified in Internal Medicine, Pulmonary Disease, and Medical Examination.

DISCUSSION AND APPLICABLE LAW

Because Claimant filed her application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. To establish entitlement to benefits under this part of the regulations, Claimant must prove by a preponderance of the evidence that the miner had pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that his death was due to pneumoconiosis. ***Peabody Coal Co. v. Director, OWCP,*** 972 F.2d 178 (7th cir. 1992).

In *Director, OWCP v. Greenwich Collieries, et al.*, 114 S. Ct. 2251 (1994), the U.S. Supreme Court stated that where the evidence is equally probative, the claimant necessarily fails to satisfy her burden of proving entitlement to benefits by a preponderance of the evidence.

Pneumoconiosis and Causation

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. In evaluating the x-ray evidence, I assign heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. *See Dixon v. North Camp Coal Co.*, 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984). Because pneumoconiosis is a progressive disease, I also may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *See Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149, 1-154 (1989) (en banc); *Casella v. Kaiser Steel Corp.*, 9 BLR 1-131, 1-135 (1986).

The evidence of record contains twenty-six interpretations of fourteen chest x-rays. Of these interpretations, thirteen were negative for pneumoconiosis while three were positive, and ten were not diagnostic of pneumoconiosis. The March 25, 1994 x-ray was interpreted as 1/1 by Drs. Aycoth and Lee, both dually qualified physicians. No physician opined that these x-rays were negative. I accord these interpretations more weight as they are the most recent x-rays reviewed for purposes of determining pneumoconiosis. Because the March 25, 1994 x-ray was interpreted as a positive reading by each dually qualified physician, I find that the x-ray evidence supports a finding of pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. In this case, each and every pathologist opined that Mr. Taylor had simple coal

workers' pneumoconiosis. Therefore, I find that the pathological evidence supports a finding of pneumoconiosis.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions apply to this claim, Claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides that a claimant may establish the presence of pneumoconiosis through a reasoned medical opinion. In this case, Drs. Ali and Howard are the only physicians that did not specifically diagnose pneumoconiosis. Dr. Ali served as Mr. Taylor's attending physician at Warrick Hospital from about 1981 until the Miner's death in 1997. His contact with the patient was typically during acute illness, and not for diagnosis of pneumoconiosis. Although he had first hand knowledge of Mr. Taylor's physical condition as it deteriorated over almost two decades, he is less qualified to render an opinion regarding pneumoconiosis than the Board Certified physicians of record. ***Burns v. Director, OWCP***, 7 B.L.R. 1-597 (1984). Further, neither Dr. Ali nor Dr. Howard were afforded the benefit of pathology reviews of Mr. Taylor's lung tissue. Therefore, I accord these physician's less weight.

Considering all the relevant factors for crediting and discrediting a physician's medical opinion, I find that the weight of the evidence of record supports a finding of pneumoconiosis.

Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. 20 C.F.R. § 718.203(b) provides:

> If a miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable

> presumption that the pneumoconiosis arose out of such employment.

I have found that Mr. Taylor was a coal miner for forty years, and that he had pneumoconiosis. Claimant is entitled to the presumption that the Miner's pneumoconiosis arose out of his employment in the coal mines. No physician opining as to the presence of pneumoconiosis offers an alternative cause to rebut this presumption. See, *Smith v. Director, OWCP,* 12 BLR 1-156 (1989). Therefore, I find that the Miner's pneumoconiosis arose from his coal mine employment.

Death and Causation

Claimant is entitled to benefits as the Miner's survivor if she demonstrates that his death was due to pneumoconiosis. 30 U.S.C. § 901(a); 20 C.F.R. § 718.205(a). 20 C.F.R. § 718.205(c) provides that:

> For the purpose of adjudicating survivors' claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> 1. Where competent medical evidence established that the miner's death was due to pneumoconiosis, or
>
> 2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or
>
> 3. Where the presumption set forth at §718.304 is applicable.
>
> 4. However, survivors are not eligible for benefits where the miner's death was caused by traumatic injury or a principal cause of death was a medical condition not related to pneumoconiosis, unless pneumoconiosis was a substantially contributing cause of death.
>
> 5. Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hasten's the miner's death.

The United States Court of Appeals for the Seventh Circuit, within whose jurisdiction this case arises, has held that pneumoconiosis will be considered a substantially contributing cause of the miner's death if it actually hastened the miner's death, even if only briefly. *Peabody Coal Co. v. Director, OWCP [Railey]*, 972 F.2d 178, 16 BLR 2-121 (7th Cir. 1992). Claimant has the burden of demonstrating by a preponderance of the evidence that pneumoconiosis was a substantially contributing cause of the Miner's death. The Supreme Court of the United States relates the term "preponderance of the evidence," to "the degree of proof which must be adduced by the proponent of a rule or order to carry its burden of persuasion in an administrative proceeding." See, *Steadman v. SEC*, 450 U.S. 91, 101 S.Ct. 999 (1981). If that degree is a preponderance, then the initial trier of fact must believe that it is more likely than not that the evidence establishes the proposition in question. *Id*.

Drs. Caffrey, Fino, Hutchins, Kleinerman, Naeye, Repsher, and Tuteur opined that Mr. Taylor's death was not caused, contributed to, nor hastened due to pneumoconiosis. Dr. Tuteur explained that Mr. Taylor's death was respiratory in nature and brought about by his chronic bronchitis, pulmonary emboli, and emphysema, but opined that pneumoconiosis did not have a role. He testified that the emboli served to "obliterate" portions of Mr. Taylor's pulmonary capillary bed by occluding vessels, causing him to have right sided congestive heart failure. He also testified that as the pulmonary capillary bed is destroyed, oxygen saturation in the blood is adversely affected, but pulmonary function testing may show little to no change.

Dr. Tuteur diagnosed Mr. Taylor with pneumoconiosis, but opined that Mr. Taylor was asymptomatic from the pneumoconiosis because "there is so much of a safety factor in the lung" that the lung can compensate for the mild pneumoconiosis. However, he invalidated all pulmonary function tests performed after 1981, limiting his ability to explain exactly how much of this "safety factor" was implicated in Mr. Taylor's pulmonary function. Dr. Tuteur did not explain whether the Miner would have survived longer if this "safety factor" had not been affected by the pneumoconiosis, as suggested by Drs. Abraham, Cohen, and Green. I find his opinion to be lacking explanation with respect to the effect the pneumoconiosis had on hastening Mr. Taylor's demise by exhausting his lung capacity and compromising his ability to recover from simultaneous pulmonary

attacks from emboli, emphysema, and chronic bronchitis. Without this explanation, it is unclear whether Mr. Taylor could have survived further obliteration of his pulmonary capillary bed, even if slight, absent pneumoconiosis. Dr. Tuteur's opinion is otherwise very well documented and reasoned, but due to this lack of explanation, I accord his opinion less weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438 (4th Cir 1997).

Dr. Fino's opinion suffers a similar lack of explanation. He specifically opines that "The quality of an opinion by a treating doctor or examining doctor or consultant on questions of impairment depends on the special training, skill, and expertise of the doctor and the availability of objective tests of lung function that can be validated according to published standards by a qualified pulmonary physician." There is no doubt that Dr. Fino is highly qualified to render an opinion, but he has invalidated every pulmonary function test since 1981, and finds the arterial blood gas studies unreliable as they were performed during acute illness. He has no reliable objective data to evaluate Mr. Taylor's pulmonary function, and therefore did not opine as to any adverse affects of the pneumoconiosis on Mr. Taylor's ability to recover from the other respiratory problems he was experiencing. I find this lack of explanation entitles his opinion to less weight. *Akers, supra*.

Furthermore, Dr. Fino opined that Mr. Taylor was totally disabled from other respiratory problems, stating that he had severely impairing chronic obstructive pulmonary disease. When questioned with respect to his diagnosis of obstructive pulmonary defects in light of invalid PFT's, he testified that "hypothetically, you can assume that also." I find his hypothetical assumptions regarding Mr. Taylor's diagnoses troubling in light of his statements that the quality of his opinion as a consultant relies heavily on objective data. I find his opinion to lack sophistication and explanation, and I find his opinion lacking a valid basis. Therefore, I accord Dr. Fino's opinion less weight. *Id.*

Dr. Hutchins opines that Mr. Taylor's pneumoconiosis did not cause or hasten death. He states that the Miner would have died at the same time had he never been exposed to coal dust. Dr. Hutchins attributes death to a combination of chronic obstructive pulmonary disease and severe congestive heart failure, but opines that neither of these processes were

contributed to by pneumoconiosis. He does not explain how he arrived at the conclusion that pneumoconiosis was not a contributing factor to Mr. Taylor's obstructive pulmonary defect. Though his opinion is well documented, this lack of explanation entitles his opinion to less weight. *Id*.

Dr. Repsher diagnoses Mr. Taylor with mild pneumoconiosis, stating that "during his life he had no symptoms or impairment resulting from his coal workers' pneumoconiosis." He also states that Mr. Taylor's pulmonary function studies were so poorly performed that none of the results were interpretable for pulmonary disease. Further, he opined that arterial blood gas studies showed hypoxemia, but criticized that most of these studies were performed during acute illness. Dr. Repsher then opines that Mr. Taylor was not suffering from any other pulmonary disease caused or aggravated by coal dust exposure in part due to the lack of pulmonary function and arterial blood gas evidence of the disease. His diagnosis of the absence of other pulmonary disease based upon the objective data which he finds nonconforming entitles his opinion to less weight. *Arnoni v. Director, OWCP*, 6 B.L.R. 1-423 (1983). Dr. Repsher attributes death to lower left lobe infarction as a result of pulmonary emboli, but makes no comment on whether Mr. Taylor's pneumoconiosis had reduced his pulmonary capacity to recover from the pulmonary emboli, as suggested by Drs. Abraham, Cohen, and Green. Absent this explanation, Dr. Repsher's opinion is due less weight. *Akers, supra*.

Both Drs. Caffrey and Naeye discuss the progression of pneumoconiosis after the cessation of exposure. Dr. Caffrey states, "It is a well known fact, which is accepted by all experts in the fields, that simple coal workers' pneumoconiosis does not progress after the miner leaves the industry." Similarly, Dr. Naeye states, "Simple CWP does not advance after a worker has left the industry." It has long been held that pneumoconiosis is a progressive and irreversible disease. *Peabody Coal Co. v. Spese*, 117 F.3d 1001 (7th Cir., 1997); *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 11 BLR 2-1 (1987) *reh'g denied*, 484 U.S. 1047 (1988); *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 3 BLR 2-36 (1976); *Stanley v. Betty B Coal Co.*, 13 BLR 1-72 (1990); *Belcher v. Beth-Elkorn Corp.*, 6 BLR 1-1180 (1984). These statements foreclose all possibility of a progression of pneumoconiosis and constitute underlying medical opinions contrary to the Act. I therefore accord Drs. Caffrey and Naeye's opinions little weight.

Dr. Kleinerman diagnosed simple pneumoconiosis, but conceded that valid pulmonary function data was unavailable to determine levels of impairment. He opined that Mr. Taylor died from cardiac failure marked with cardiac hypertrophy of the bi-ventricular type. He further opined that the cardiac failure resulted in pulmonary edema. Dr. Kleinerman concluded that pneumoconiosis did not contribute to Mr. Taylor's cardiac failure and ultimate death. Dr. Kleinerman's report is well reasoned and documented. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987).

Dr. Jones provided the cause of death information on Mr. Taylor's death certificate, and also provided a report chronicling the autopsy and pathology examination. I give Dr. Jones' opinion increased weight with respect to the condition of Mr. Taylor's heart because he was the prosector performing the autopsy. The Seventh Circuit Court of Appeals has recently stated that, "If there were a medical reason to believe that visual scrutiny of gross attributes is more reliable than microscopic examination of tissue samples as a way to diagnose pneumoconiosis, then relying on the conclusions of the prosector would be reasonable." *Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001). In this case, each pathologist found evidence of coal workers' pneumoconiosis, but Dr. Jones was able to offer added insight from his gross anatomical examination. He examined the heart, finding cor pulmonale, a finding which is disputed by Drs. Caffrey, Fino, and Naeye. Dr. Fino, however, admits that the prosector is in a better position in this case to evaluate cor pulmonale. Dr. Jones opined that the respiratory failure causing Mr. Taylor's death was due, in part, to his cardiac failure. He attributed the cor pulmonale to pneumoconiosis, thus concluding that pneumoconiosis hastened Mr. Taylor's death. His opinion is well documented and reasoned, and he performed the autopsy, entitling his opinion to increased weight. *Fields, supra*.

Dr. Abraham concluded that Mr. Taylor's lungs were damaged by pneumoconiosis and suffered a decrease in pulmonary function which led to his cardiac and respiratory failure. All of the pulmonary function tests since 1981 have been invalidated by various physicians. Dr. Abraham does not cite the specific studies which form the basis for his opinion regarding a decrease in pulmonary function, nor does he offer an explanation of how those studies were sufficiently valid to support his conclusions. I find his report lacks adequate documentation to

support his conclusion and therefore accord his opinion less weight. *Akers, supra.*

Dr. Green opined that Mr. Taylor's death was due to respiratory failure, brought about by pneumoconiosis, chronic obstructive pulmonary disease, bronchitis, and emphysema. He opined that the etiology of each of these diseases was, at least in part, exposure to coal dust. He also diagnosed cor pulmonale noting that both emphysema and bronchitis are known causes. As further support for his diagnosis, he noted changes in the pulmonary arteries and arterioles consistent with cor pulmonale. Dr. Green based his opinion, in part, upon rapidly decreasing pulmonary function, but did not discuss the validity of the pulmonary function tests performed after 1981. As his opinion is based upon pulmonary function tests that are invalid, I accord his opinion less weight. *Arnoni v. Director, OWCP*, 6 B.L.R. 1-423 (1983).

Dr. Cohen specifically addresses the combined effect of Mr. Taylor's recurrent pulmonary emboli, and his underlying lung diseases. He opines that, according to the 1994 spirometry, the Miner suffered from a combination of restrictive and obstructive defect. Dr. Cohen, as well as consultant Tom Kennedy, M.D., finds the June 23, 1994 study to be interpretable. Dr. Cohen is as qualified to opine that this study is interpretable as any other physician opining to its invalidity. He further opines that Mr. Taylor's coal dust induced diseases so compromised lung function that he was unable to withstand the combined insults of pneumonia and recurrent pulmonary emboli. I find his opinion well documented and reasoned. *Fields, supra.*

Weighing these reports together, I give the most weight to the opinions of Drs. Cohen and Jones. Both physicians are highly qualified, gave well documented and reasoned opinions, and sufficiently explained their diagnoses in light of their findings. Considering all the relevant factors for crediting and discrediting a physician's medical opinion, I find that the weight of the evidence of record supports a finding that Mr. Taylor died as a result of multiple and recurrent pulmonary diseases, but that his death was hastened by his underlying pneumoconiosis. Accordingly, I find that the weight of the medical evidence demonstrates by a preponderance of the evidence that Mr. Taylor's death was due to pneumoconiosis, as defined in §718.205. By reason of the foregoing, it is concluded that Isabell Taylor is entitled to benefits.

ENTITLEMENT

Twenty C.F.R. Section 725.503(c) provides as follows:

> Benefits are payable to a survivor who is entitled beginning with the month of the miner's death, or January 1, 1974, whichever is later.

Where it is determined that the miner died due to pneumoconiosis, entitlement to benefits properly commences as of the first day of the month of the year of the miner's demise. *Mihalek v. Director, OWCP*, 9 BLR 1-157 (1986). The miner died on June 14, 1997. Therefore, Claimant is entitled to benefits commencing on June 1, 1997.

ORDER

Rag American Coal Company is ordered to pay:

To Claimant, Isabell Taylor, all benefits to which she is entitled under the act commencing June 1, 1997.

ATTORNEY'S FEES

An award of attorney's fees for services to the claimant has not been made in this decision since no application has been filed by counsel. Fifteen days from the date of receipt of the Decision and Order is allowed to claimant's counsel for the submission of a legal fee application. A service sheet showing that service has been made upon all parties, including the claimant, must accompany the application. The Director will have 15 days following the mailing date of the application within which to file objections. If no response is received within this 15 day period, the Director will be deemed to have waived any objection to the fee requested.

In preparing the attorney fee schedule, the attention of counsel is directed to the provisions of Regulations Sections 725.365 and 725.366. In conjunction with each of those regulations and in considering applicable case law, IT IS ORDERED that the fee petition filed in this case shall include each of the following:

1. A complete statement of the extent and character of each separate service performed shown by date of performance;

2. An indication of the professional status (e.g., attorney, paralegal, law clerk, lay representative, or clerical of the person performing each quantum of work and that person's customary billing rate;

3. A statement showing the basis for the hourly rate being charged by each individual responsible for the rendering of services;

4. A statement as to the attorney or other lay representative's experience and expertise in the area of Black Lung law;

5. A listing of reasonable unreimbursed expenses, including travel expenses; and

6. A description of any fee requested, charged, or received for services rendered to the Claimant before any State or Federal Court of Agency in connection with a related matter.

A
Rudolf L. Jansen
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision, by filing a Notice of Appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601 (20 C.F.R. Section 725.481). A copy of the Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.